Carolina Pediatrics
OF THE TRIAD, PA

2707 Henry Street, Greensboro, NC 27405
phone: 336-574-4280 fax: 336-574-4634 www.cptriad.com

Peter J. Jarosak, M.D. Edgar W. Little, M.D. Charles B. Brett, M.D. Mark M. Brassfield, M.D. Melissa V. Lowe, M.D. W. Brad Davis, M.D. Brian A. Sumner, M.D. Rebecca E. Keiffer, M.D. Alan W. Cooper, M.D. Melisa K. Lyles, M.D. Carey C. Williams, M.D.

FINANCIAL POLICY

It is our policy to keep your health care costs as low as possible. In order to do this, we need to keep our billing costs to a minimum. Please help us in the following ways:

- ✓ Always bring your current health insurance card to the office.
- ✓ Always notify us at the time of check-in of all changes in insurance, address, phone number, e-mail address, etc.
- ✓ Always pay your co-pay or deductible in full at the time of service. If you do not have insurance, please come prepared to pay for your visit in full at the time of service. We accept cash, check, and all major credit cards.
- ✓ Always verify and understand the benefits of your insurance plan. There may be services provided that your insurance plan does not cover.

Payment options if you have an insurance plan with a co-pay: We are required by our insurance contracts to collect your co-pay at the time of service.

Payment options if you have an insurance plan with a deductible: We are required by our insurance contracts to collect your balance of the deductible. We ask that you pay at least $50.00 towards your balance at the time of service.

Payment options if you have NO insurance: We give our uninsured patients a 25% discount. If payment is made in full at the time of service, we give an additional 10% discount. If you are unable to pay in full at the time of service, we will arrange a budget agreement in which you will agree to have your balance paid in full within 90 days with the 1st payment payable at the time of service.

Insurance release: This is to certify that you have been informed prior to receiving treatment that your health plan may not be liable for services rendered if any of the following apply:

- ✓ You may have a pre-existing condition or other diagnosis that may not be covered by your plan
- ✓ Provider not participating in your health plan
- ✓ Unmet deductible under your health plan contract
- ✓ Unpaid co-pay or co-insurance under your health contract
- ✓ Specific services may not be covered by your health plan.

You agree to pay any portion of charges for which your health plan is not liable.

Monthly statements: If you have a balance on your account, we will send you a monthly statement. It will reflect your previous balance, new charges to your account, and any payments or credits applied to your account during the month. Unless we have an agreed upon budget arrangement on file, the balance of your statement is due and payable when you receive your statement.

Minimum balance: We will not send statements for balances less than $25.00. We may contact you by phone to obtain this balance or may ask for payment at your next office visit.

Credits: For credit balances greater than $25.00, we will mail a check to you. These checks will be mailed once a month. For credit balances less than $25.00, your credit will remain on your account and will be applied to future charges on your account. We will only mail checks for credits less than $25.00 when you request it.

Past due accounts: If your balance is not paid in full within 30 days, your account is past due. We will take the necessary steps to collect this debt including referral to a collection agency. If there becomes a need to send the balance of your account to collections due to non-payment of the balance, the physicians of Carolina Pediatrics of the Triad, P.A. may no longer be able to provide care to your child/children. In this case, the guarantor will be notified by certified mail and given 30 days to find a new medical provider. A processing fee will be applied to these past due accounts. All accounts sent to the collection agency will be reported to the Credit Bureau.

Custody: The parent authorizing treatment for the child/children will be the parent responsible for those subsequent charges. If custody papers require one parent to pay part or all medical expenses, it is the authorizing parent's responsibility to collect the expenses from the other parent.

After-hours fee: For appointments after 5:00pm (Monday-Friday) and for all weekend appointments, there is a $40.00 fee that is billed in addition to charges accrued at your visit. Most insurance plans cover this fee. However, if yours does not, you will be billed for the fee.

Forms: There is a $5.00 fee for the completion of standard school, sports, and/or daycare forms. There is a $10.00 fee for the completion of FMLA forms or other time-intensive forms.

Returned checks: You will be charged a $25.00 fee for any checks returned by the bank.

No show fee: You will receive a separate form detailing our No Show Policy and fees. Missed well checks are charged as: 1st $20, 2nd and 3rd $50. Sick visits are charged as: 1st $10, 2nd and 3rd $25. After the 3rd no show (well or sick), the physicians at Carolina Pediatrics of the Triad, P.A. may no longer be able to provide care to your child/children. In this case, the guarantor will be notified by certified mail and given 30 days to find a new medical provider.

Medical record fee: You will need to complete an authorization form to obtain a copy of records or to have records sent to another provider. This form can be obtained from our office or our website. There is a processing fee for medical records. For one patient, we charge $20.00. For a family, we charge $30.00.

Effective dates: Once you have signed this agreement, you agree to all terms and conditions contained herein, and the agreement will be in full force and effect.

Agreement: This is an agreement between Carolina Pediatrics of the Triad, P.A., as creditor, and the Patient/Parent/Guardian, as debtor, named on this form. In this agreement, the words "you", "your", and "yours" mean the patient/debtor. The word "account" means the account that has been established to your name to which charges are made and the payments credited. The words "we", "us", and "our" refer to Carolina Pediatrics of the Triad, P.A.

By executing this agreement, you are agreeing to pay for all services that are received. Knowing this, I request that services be performed and I agree to be responsible for any charges incurred. I understand that if I fail to make payments when due and my account becomes delinquent or is turned over to a collection agency or attorneys for collections, the undersigned shall pay all collection agency fees, court costs, and attorney fees, and risks being dismissed from the physician care of Carolina Pediatrics of the Triad, P.A.

I have read this Financial Policy as outlined above and on the reverse side of this page and understand that I am ultimately responsible for the charges incurred by my child/children as their legal parent or guardian.

Patient Name (s) ____

Parent/Guarantor Signature ____________________________________

Date ____________________